Form 230
Revised 3/30/04

"This form, when filled in, contains patient information that must be protected in accordance with the Health Insurance Portability & Accountability Act."

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Please complete a separate form for each specimen. Yellow copy may be retained by the submitter.

Clinical Chemistry

PATIENT INFORMATION:

Name (Last, First, MI) _____

Social Security # _____ Sex _____ Race _____ Age _____ DOB _____

Home Address _____

City _____ State _____ Zip Code _____ County _____

Send Report To:

Submitter _____

Street Address (PO BOX) _____

City _____ State _____ Zip Code _____

Please Use "L" Label or Fill in Completley

Specimen Information:

Specimen Collection: Date _____ Time _____ AM PM

Is the patient Fasting: ☐ Yes ☐ No Is the patient Pregnant? ☐ Yes ☐ No

Please fill in for timed glucose specimens as applicable:

Fasting _____ Collection time
1 Hour _____ Collection time
2 Hour _____ Collection time
3 Hour _____ Collection time

Examination Requested: *Must indicate test to be performed. (See Reverse Side.)*

- ☐ Total Cholesterol (only)
- ☐ Lipid Profile
- ☐ Lithium (Patient must have an order from a Comprehensive Care physician prior to testing.)
- ☐ Fasting Plasma Glucose*
- ☐ Random Plasma Glucose*
- ☐ Prenatal 1 Hour Glucose*, Post 50 gm. Load
- ☐ Postpartum Fasting Plasma Glucose*
- ☐ GlucoseTolerance Test*, Prenatal / Postpartum *(circle one)*

*Specimens must be mailed in an appropriate container with ice pack

For Cholesterol and Lipid Profile please indicate the program and mark the risk factors:

PROGRAM : ☐ Family Planning ☐ Chronic Disease

RISK FACTORS:

- ☐ Cigarette Smoker
- ☐ Hypertensive
- ☐ Family History of Premature CHD
- ☐ Diabetes Mellitus
- ☐ Obesity (30% Overweight or Greater)
- ☐ Age 40 or Over
- ☐ Family History of High Cholesterol
- ☐ Sedentary Lifestyle